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Nos. 99-1156 and 99-1177

Supreme Court, U.S.
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In The

Supreme Court of the United States

PLANNED PARENTHOOD OF WISCONSIN, et al.,

Petitioners,

v.

JAMES E. DOYLE, et al.,

Respondents.

DENNIS D. CHRISTENSEN, M.D., et al.,

Petitioners,

v.

JAMES E. DOYLE, et al.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

COMBINED MEMORANDUM OF RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the Seventh Circuit Court of Appeals correctly deferred to the will of the Wisconsin Legislature in finding that the definition of "partial-birth abortion" in Wisconsin Stat. § 940.16 was not unconstitutionally vague and could be read to apply to only one method of abortion.

2. Whether the Wisconsin Legislature's limiting the availability of one method of abortion, when there are other equally safe or safer methods of abortion available, creates an undue burden on women in Wisconsin seeking abortions.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 2

I. THE DECISION OF THE COURT OF APPEALS CONFLICTS WITH DECISIONS FROM ANOTHER CIRCUIT. 3

II. THIS CASE PRESENTS IMPORTANT CONSTITUTIONAL QUESTIONS. 3

III. THIS CASE RAISES ISSUES THAT SHOULD BE CONSIDERED BY THIS COURT IN ADDITION TO THE ISSUES RAISED IN *STENBERG v. CARHART*. 4

CONCLUSION 7

CASES

Carhart v. Stenberg,
192 F.3d 1142 (8th Cir. 1999),
sub nom. Stenberg v. Carhart,
cert. granted, 68 U.S.L.W. 3449
(U.S. Jan. 14, 2000) (No. 99-830) ..... passim

Little Rock Family Planning Services v. Jegley,
192 F.3d 794 (8th Cir. 1999) 3

Planned Parenthood v. Casey,
505 U.S. 833 (1992) 4

Hope Clinic v. Ryan,
195 F.3d 857 (7th Cir. 1999) 1, 6

Planned Parenthood of Wisconsin v. Doyle,
44 F.Supp.2d 975 (W.D. Wis. 1999) 2

Planned Parenthood of Greater Iowa, Inc. v. Miller,
195 F.3d 386 (8th Cir. 1999) 3

Stenberg v. Carhart,
cert. granted, 68 U.S.L.W. 3449
(U.S. Jan. 14, 2000) (No. 99-830) 2, 4, 7

STATUTES

Wis. Stat. § 940.16 i

Wis. Stat. § 940.16(1)(b) 5

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Respondents do not oppose the petitions for writs of certiorari seeking review of the Seventh Circuit's opinion in this case, limited to the issues of constitutional vagueness and "undue burden." The opinion of the Seventh Circuit is reported at 195 F.3d 857 (7th Cir. 1999).

Respondents are prepared to keep the briefing schedule the Court has set in another challenge to a partial-birth abortion statute, *Carhart v. Stenberg*, 192 F.3d 1142 (8th Cir. 1999), *sub nom. Stenberg v. Carhart*, *cert. granted*, 68 U.S.L.W. 3449 (U.S. Jan. 14, 2000) (No. 99-830), if the Court desires to consider the two cases simultaneously.

STATEMENT OF THE CASE

Respondents incorporate by reference the Findings of Fact made by the district court (Pet. App. 75a-88a[1]; reported at 44 F.Supp.2d 975, 977-82 (W.D. Wis. 1999)) and the Amended Stipulation of Facts entered into by the parties prior to trial (R-Ap. 1a-26a).

Respondents note that petitioners did not offer any evidence relevant to a part of the fourth question presented in Planned Parenthood's petition (Question 2.(d) in Christensen's petition)—whether the language in Wisconsin's statute permits partial-birth abortions when necessary to save women's lives. The issue was not listed in the parties' Joint Pre-Trial Report as an issue to be raised. The issue was not addressed by either the district court or the court of appeals. The issue has therefore been waived.

REASONS FOR GRANTING THE WRIT

Respondents agree with petitioners that this case is certworthy. Circuit courts are split on the issue of the constitutionality of State partial-birth abortion statutes. This case presents important federal constitutional questions concerning the vagueness standard for abortion statutes and the "undue burden" test as applied to limiting the use of one

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[1] Citations to "Pet. App." are to the Appendix of Planned Parenthood's petition, No. 99-1156.

method of abortion when there are equally safe or safer alternative methods available. These questions were not reached by the Eighth Circuit in *Carhart v. Stenberg*, 192 F.3d at 1146 n.4.

However, respondents disagree with petitioners' claim that the court of appeals' decision conflicts with any precedent of this Court.

Respondents support the grant of certiorari limited to the questions of whether Wisconsin's partial-birth abortion statute is unconstitutionally vague and whether, assuming it limits only one method of abortion, the statute imposes an "undue burden" on women in Wisconsin seeking abortions.

I. THE DECISION OF THE COURT OF APPEALS CONFLICTS WITH DECISIONS FROM ANOTHER CIRCUIT.

The Seventh Circuit's determination in this case that Wisconsin's partial-birth abortion statute is constitutional conflicts with the decision of the Eighth Circuit in *Little Rock Family Planning Services v. Jegley*, 192 F.3d 794 (8th Cir. 1999), in which that court, construing a statute worded similarly to Wisconsin's, construed it broadly and found it to be unconstitutional. *See also* the Eighth Circuit's decisions in *Carhart v. Stenberg*, 192 F.3d 1142, and *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386 (8th Cir. 1999).

II. THIS CASE PRESENTS IMPORTANT CONSTITUTIONAL QUESTIONS.

Thirty states have enacted legislation limiting the availability of the partial-birth method of abortion. *See* Pet. App. 25a; Planned Parenthood Pet. at 19 n.12. District

courts and courts of appeal have prohibited the application of the laws in two-thirds of the states. Pet. App. 25a. Petitioners have provided citations for at least some of the litigation that has been generated. *See* Planned Parenthood Pet. at 8 n.4.

Respondents agree with petitioners that this case presents important federal questions concerning the constitutionality of the various States' legislation. The fact that this Court has granted certiorari in *Stenberg v. Carhart*, No. 99-830, speaks directly to the importance of the federal questions raised by this case too. This case would settle the question of whether, under this Court's precedent, a State can limit the availability of one method of abortion when other equally safe or safer methods remain available, an issue that may not be answered by the decision in *Stenberg v. Carhart*, No. 99-830.

III. THIS CASE RAISES ISSUES THAT SHOULD BE CONSIDERED BY THIS COURT IN ADDITION TO THE ISSUES RAISED IN *STENBERG v. CARHART*.

Review of this case, in addition to *Stenberg v. Carhart*, No. 99-830, is warranted because of the significant differences between Wisconsin's statute limiting partial-birth abortions and Nebraska's, and between the records presented to the district courts in Wisconsin and Nebraska. This case also squarely presents the issues of the vagueness standard to be used for abortion statutes and of whether it is an "undue burden" (the test used in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)) to limit the availability of one method of abortion if other equally safe or safer methods are available. The lower courts in *Stenberg v. Carhart*, No. 99-830, never reached these issues because they held that Nebraska's partial-birth abortion statute would be an undue burden because it banned the equally safe or safer methods.

Carhart v. Stenberg, 192 F.3d at 1146 n.4, 1150. The Wisconsin court did address these issues, specifically finding that Wisconsin's statute would not pose an undue burden if it were narrowly construed to apply only to the rare D&X (dilation and extraction) method of abortion and not the common suction curettage, D&E (dilation and evacuation) and induction methods of abortion. In this Wisconsin case there is a record and detailed findings of fact on the issues.

Nebraska's statute prohibits a person from "'deliberately and intentionally delivering into the vagina a living unborn child, *or a substantial portion thereof*, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.' Neb. Rev. Stat. § 28-326(9) (1998)." *Carhart*, 192 F.3d at 1150 (emphasis added). The Eighth Circuit held that "[t]he *crucial* problem is the term 'substantial portion'" and found that an arm or a leg is "substantial." *Id.* (emphasis added). Accordingly, if under the common D&E method of abortion the physician "dismembered" an arm or a leg that would be a "substantial portion" of the fetus delivered into the vagina and Nebraska's statute would be violated.

Wisconsin's statute does not contain the "substantial portion" language that troubled the Eighth Circuit. *See* Wis. Stat. § 940.16(1)(b).[2] The Wisconsin statute requires the delivery of an intact body into the vagina. Wis. Stat. § 940.16(1)(b). Petitioners Christensen and Smith specifically distinguished the D&X abortion procedure from other procedures on this basis, "[t]he intentional removal of the fetus intact is what distinguishes an intact D&E [D&X] procedure from a D&E procedure." Stip. ¶ 65, R-Ap. 14a.

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[2] Wis. Stat. § 940.16(1)(b): "'Partial-birth abortion' means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child."

Similarly, the Seventh Circuit noted, that in the D&X, as contrasted with the D&E, the fetus is "removed without dismemberment" and it is "this combination of coming so close to delivering a live child with the death of the fetus by reducing the size of the skull that not only distinguishes D&X from D&E medically but also causes the adverse public (and legislative) reaction." Pet-App. 4a-5a.

Unlike in the Nebraska case, the parties in this case entered into an extensive stipulation of facts. R-Ap. 1a-26a. The evidence presented at the trial in Wisconsin showed the Legislature intended to limit only one method of abortion, known to physicians as "dilation and extraction" or "D&X" and to laypeople as "partial-birth abortion." The district court and the court of appeals limited the statute accordingly (unlike the Eighth Circuit's approach). The Seventh Circuit even declined respondents' request that any question of statutory interpretation be certified to the Wisconsin Supreme Court.

Respondents note that in *Hope Clinic v. Ryan*, No. 99-1152, both petitioners and respondents have also asked this Court to review the Seventh Circuit's decision in this case (the cases were heard together *en banc* and one consolidated opinion was issued). Respondents here agree with the Illinois respondents that contemporaneous review of the Seventh and Eighth Circuits' opinions would provide the Court with a broader picture of the relevant statutory, factual and legal underpinnings of partial-birth abortion issues. Respondents note that the Seventh Circuit itself consolidated the appeals of the challenges to Illinois' and Wisconsin's partial-birth abortion statutes and therefore had a broader spectrum of information available to it.

CONCLUSION

For the reasons given above, respondents respectfully request that the petitions be granted and heard by the Court in conjunction with *Stenberg v. Carhart*, No. 99-830.

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February 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

PLANNED PARENTHOOD OF WISCONSIN; GARY T. PROHASKA, M.D.; FREDRIK F. BROEKHUIZEN, M.D.; GAVIN JACOBSON, M.D.; NEVILLE SENDER, M.D.; DENNIS D. CHRISTENSEN, M.D.; and BERNARD SMITH, M.D., on behalf of themselves and their patients seeking abortions Plaintiffs, vs.	No. 98-C-0305-S
JAMES E. DOYLE, in his official capacity as the Attorney General of the State of Wisconsin; and DIANE M. NICKS, in her official capacity as District Attorney for Dane County and as representative of a class of all District Attorneys in Wisconsin, Defendants.	

AMENDED STIPULATION OF FACTS

As a result of review of the proposed findings of fact submitted by the parties, the parties have agreed to stipulate to additional facts. For the convenience of the Court, the parties have prepared the following stipulation in order to set forth in a single stipulation the facts to which the parties stipulated in the Pretrial Report and the facts to which the parties have subsequently agreed:

1. Plaintiff Planned Parenthood of Wisconsin, Inc. (Planned Parenthood) is a not-for-profit Wisconsin charitable corporation. Planned Parenthood provides abortion services through the first sixteen weeks of pregnancy measured from the woman's last menstrual period (LMP). Abortions are provided at two clinics, one in Milwaukee and one in Appleton. Planned Parenthood employs physicians who use surgical procedures that Planned Parenthood fears may fall within the proscriptions of the Act.

2. Plaintiff Fredrick F. Broekhuizen, M.D., is a physician licensed to practice medicine in the State of Wisconsin. He is Chair of the Department and Professor of Obstetrics and Gynecology at the University of Wisconsin Medical School's Milwaukee Clinical Campus. He is a Board Certified Obstetrician/Gynecologist (OB/GYN) and a Fellow of the American College of Obstetricians and Gynecologists. In addition to his teaching duties, he has a medical practice that focuses on perinatology: the management of pregnancies complicated by maternal or fetal disease. As a part of that practice he performs between 100 and 120 abortions per year, all in a hospital setting. The vast majority of these procedures are performed for medical reasons. Some relate to a pre-existing medical condition of the woman that makes continuation of the pregnancy detrimental to her health. Most relate to congenital anomalies or chromosonal anomalies detected during testing and screening of the pregnancy. Plaintiff Broekhuizen fears that some of the abortions he performs will subject him to liability under the Act.

3. Plaintiff Gavin Jacobson, M.D., is a physician licensed to practice medicine in the State of Wisconsin. He is a Board Certified OB/GYN and a Fellow of the American College of Obstetricians and Gynecologists. He is an Assistant Professor in the Department of Obstetrics and Gynecology of the University of Wisconsin School of Medicine Milwaukee Clinical Campus. His medical practice

involves a full range of obstetric and gynecological services. A major part of his practice involves the medical management of high-risk or complicated pregnancies. As an integral part of this practice, he performs abortions. Plaintiff Jacobson fears that some of the abortions he performs will subject him to liability under the Act.

4. Plaintiff Neville Sender, M.D., is a physician licensed to practice in the State of Wisconsin. He is a Board Certified OB/GYN and a Fellow of the American College of Obstetricians and Gynecologists. He has a general obstetrics and gynecology practice in Milwaukee. As part of his practice, he provides abortions for his patients. He also provides abortions one day each week at the Summit Women's Clinic in Milwaukee. Plaintiff Sender fears that he could be subject to liability under the Act for some of the abortions he provides.

5. Plaintiff Gary Prohaska, M.D., is a physician licensed to practice medicine in Wisconsin, Nebraska, Oregon and California. He is Board Certified in OB/GYN and a Fellow of the American College of Obstetricians and Gynecologists. Dr. Prohaska provides abortion services for plaintiff Planned Parenthood. Dr. Prohaska fears that he would be subject to liability under the Act for some of the abortions he provides.

6. Plaintiff Dennis D. Christensen, M.D., is a physician licensed to practice in Wisconsin, Michigan, Illinois, Iowa and Indiana, and is Board Certified in Obstetrics and Gynecology. He is a Clinical Assistant Professor at the University of Wisconsin Medical School Department of Obstetrics and Gynecology. He performs abortions up to 24 weeks LMP at the Madison Abortion Clinic in Madison, Wisconsin. In 1998, he performed approximately 2550 abortions in Wisconsin; of these, approximately 300 were second-trimester procedures. Dr.

Christensen fears that he would be subject to liability under the Act for some of the abortions he provides.

7. Plaintiff Bernard Smith, M.D., is a physician licensed to practice medicine in Wisconsin and Michigan, and is Board Eligible in Emergency Medicine. He performs abortions up to 22 weeks LMP at Affiliated Medical Services in Milwaukee, Wisconsin. In 1997, he performed approximately 3,000 abortions in Wisconsin; of these, approximately 500 were second-trimester procedures. Dr. Smith fears that he would be subject to liability under the Act for some of the abortions he provides.

8. Defendant Diane Nicks is the District Attorney for Dane County. She is responsible for enforcement of the Act. She is sued in her official capacity and as a class representative under Fed. R. Civ. P. 23(b)(1) of all district attorneys in Wisconsin.

9. Defendant James E. Doyle is the Attorney General of Wisconsin. He is sued in his official capacity.

10. The Act forbids any person from intentionally performing a "partial-birth abortion." A "partial-birth abortion" is defined as "an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes delivery of the child." AB220 (1)(b). "Child" is defined as a "human being from the time of fertilization until it is completely delivered from a pregnant woman." Wis. Stat. § 940.16.

11. The Act provides an exception to its criminal sanction: where a partial-birth abortion "is necessary to save the life of a woman whose life is endangered by a physical disorder, physical illness, or physical injury . . . if no other medical procedure would suffice for that purpose."

12. Violation of the Act is a class "A" felony under Wisconsin law, subjecting violators to life imprisonment.

13. The Act also creates civil liability for its violation. It authorizes, "the father of the child aborted by the partial-birth abortion" and, if the woman on whom the abortion was performed is a minor, either of her parents to sue for damages. Either may sue regardless of whether the woman consented to the partial-birth abortion. However, neither may sue if he or she consented to the partial-birth abortion. Wis. Stat. § 895.038.

14. In enacting the Act, the Wisconsin legislature rejected proposed amendments. The amendments are Exhibits 1 - 15.

15. At the beginning of any abortion procedure, the fetus or embryo is ordinarily alive.

16. The purpose of any abortion procedure is to terminate a pregnancy by completely evacuating the woman's uterus.

17. Terminating a pre-viable pregnancy will, by design, kill the fetus or embryo aborted.

18. Physicians who perform abortions know that the steps they take to terminate a pre-viable pregnancy will kill the fetus or embryo aborted.

19. In no abortion procedure does the physician try to ensure that the fetus or embryo remains alive until some particular time in the procedure or until the fetus or embryo is located at some particular point in the woman's body.

20. Physicians do not usually monitor the time of fetal demise during abortion procedures. Sometimes, however, the physician is aware of the moment of fetal demise. For example, in some procedures, the physicians senses the throbbing of the umbilical cord or fetal movement, both of which indicate that the fetus is alive. The moment of fetal demise can also sometimes be ascertained by ultrasound or other means.

21. In any abortion, a physician's goal is minimize risk to the woman. At a minimum this includes: once the procedure has started, concluding it as quickly as possible, minimizing loss of blood during the procedure, and minimizing both the number of times and the distance he must insert instruments into the woman's uterus.

22. The number of induced abortions reported as occurring in Wisconsin in 1997 was 13,218. The total number of abortions reported for Wisconsin residents in 1997 was 12,675. These abortions occurred in the following gestational age ranges:

weeks of gestation	number	Percent
8 or less	6,913	52%
9-12	4,667	35%
13-15	813	6%
16-20	662	5%
Over 20	163	1%

23. Abortions are performed by various procedures. The choice of procedure depends on a range of factors, including the gestational age of the fetus, the woman's health, medical conditions of the woman, the physician's skill, the woman's preferences, the woman's prior surgical history, the woman's concern about preserving her fertility, and the need to have an intact fetus for genetic and other testing.

24. Abortions are not part of emergency room practice.

25. Manual examination to determine gestational age is not accurate.

26. The following paragraphs describe various methods of abortion and refer to "the physician." This term is meant to include at least some, if not all, of the plaintiff physicians, depending on which procedure is being described.

Suction Curettage Abortion Procedures

27. The most common method of first trimester abortion is suction curettage. In a suction curettage procedure, the physician generally dilates the cervix, inserts a tube (cannula) through the vagina and the cervix into the uterus, and removes the embryo or fetus and other products of conception through the cannula while it is inside the vagina, cervix, and uterus.

28. The embryo or fetus is often still alive after it has been removed from the uterus. When a portion of the fetus has been evacuated with suction and other parts of the fetus remain in the uterus, the part that remains in the uterus will also sometimes be alive.

29. A physician who performs a suction curettage procedure understands that fetal demise is the inevitable outcome of the steps he takes to complete the procedure.

30. In performing a suction curettage abortion, the physician will sometimes make multiple passes into the uterus with the cannula. This can occur in situations where the cannula becomes clogged and must be removed and it can occur in situations where the physician completes one pass with the suction, then discovers with a curette that tissue

remains in the uterus, and decides to again use suction to try to remove the tissue. In addition, some physicians routinely make multiple passes into the uterus, withdrawing the cannula between each, in their attempt to completely evacuate the uterus.

31. In performing a suction curettage procedure, the physician sometimes does not completely evacuate the uterus with the suction machine and will use forceps to remove some part or parts of the products of conception.

32. When this occurs, the physician inserts the forceps into the uterus, grasps whatever tissue he or she first encounters, and pulls it down through the vagina.

33. The tissue removed with the forceps will be sometimes be part or all of the fetus, and other times will be part or all of the umbilical cord or placenta.

34. Physicians who perform suction curettage abortions know that suctioning a pre-viable fetus or embryo out of the uterus or removing it by forceps will cause the fetus or embryo to die within a few minutes.

35. The most common method of second-trimester abortion is the dilation and evacuation (D&E) procedure. The D&E procedure is used once the fetus is too large to remove simply by means of suction.

36. In a D&E procedure, the physician generally dilates the cervix by inserting laminaria (an osmotic dilator placed in the woman's cervix, which absorbs natural moisture and expands, dilating the cervix). Sufficient dilation of the cervix can involve serial removal and reinsertions of laminaria, depending on the gestational age of the fetus and the responsiveness of the woman's cervix to the dilation process. When sufficient dilation has been achieved,

after removing all laminaria, the physician will rupture the membranes (amniotic sac).

37. Depending on the gestational age and the size of the fetus and the amount of dilation achieved, the physician may use suction to remove the parts of the fetus and products of conception that are removable by suction. The physician will then insert forceps into the woman's uterus in order to grasp and remove the remaining parts of the fetus from the uterus through the cervix into the vagina and then out of the woman's body. This process frequently involves dismemberment of the fetus and repeated insertions of the forceps into the woman's uterus to grasp and remove remaining fetal parts.

38. During an abortion performed in the manner described in the preceding paragraph, there often is fetal cardiac activity and other signs of life after a fetal part has been delivered into the vagina while the remainder of the fetus is in utero.

39. In some D&E procedures, the first fetal part that the physician grasps with the forceps is the fetal head.

40. When this occurs, the physician usually crushes the calvarium (skull) before drawing it through the cervix into the vaginal canal.

41. Physicians who perform abortions know that crushing the calvarium will cause the fetus to die immediately or within a few minutes.

42. During some D&E procedures, again depending on the gestational age and the size of the fetus and the response of the woman's cervix to the dilation process, there will be sufficient dilation of the cervix to allow the physician to extract a fetus intact. When an abortion

proceeds in this fashion, there is minimal insertion of forceps into the woman's uterus.

43. During an abortion performed in the manner described in the preceding paragraph, there will sometimes be fetal cardiac activity and other signs of life after some part of the fetus has been delivered into the vagina.

44. When a procedure proceeds in the manner described in paragraph 42, the physician will, after evaluating the circumstances, sometimes attempt to remove the fetus intact. This may occur in circumstances in which the physician set out to do a D&E procedure in which he or she expected dismemberment to occur.

45. During some D&E procedures, again depending on the gestational age and size of the fetus and the response of the woman's cervix to the dilation process, the physician will extract the fetus intact into the vagina, but the fetal skull will lodge in the cervix, at which point the physician will compress the skull to complete the extraction.

46. When an abortion proceeds as described in the preceding paragraph, fetal cardiac activity and other signs of fetal life may continue after the fetus has been partially extracted intact into the vagina and before the skull is compressed, as well as after the fetus has been completely extracted.

47. Martin Haskell, M.D. is a physician who has performed over 2000 abortions by method that he refers to as intact dilation and extraction ("D&X). Dr. Haskell believes D&X is one method of abortion on a continuum with D&E. In this procedure, the physician extracts the fetus intact until the head is lodged in the cervix. The physician inserts a sharp instrument to puncture the base of the fetal skull, and then uses suction to evacuate the cranial contents in order to collapse the skull and complete the extraction of the fetus.

Alternatively, in order to collapse the skull and complete the extraction of the fetus, the physician will insert forceps designed to crush the skull, and will crush the skull. Dr. Haskell believes that there are other methods of dealing with the skull and completing an extraction of an intact fetus in addition to those in the preceding paragraph that would also fit within his understanding of a D&X.

48. Dr. Haskell coined the term D&X as a description to help physicians reconceptionalize their approach to D&E abortions by having the goal to extract the child more intact up to the calvarium.

49. At the time of his deposition, Dr. Haskell did not believe he read the articles on partial-birth abortion in JAMA.

50. After 20 weeks gestational age, Dr. Haskell does not always try to do a D&X; instead, his choice of method depends on the amount of dilation and the presentation of the child.

51. Dr. Haskell does not discuss the D&E compared to the D&X methods with his patients.

52. Dr. Haskell's consent form does not distinguish between the D&E and D&X methods of abortions.

53. While Dr. Haskell believes D&X's are safer, he does not always do them because it can mean "an additional 24 hours of laminaria" with the "risk that [the woman's] membranes might rupture or she may develop an infection." The surgeon may have a preference or the convenience for the woman may play a role.

54. Dr. Haskell uses the same anesthetics for D&E and D&X abortions.

55. Dr. Haskell's practice consists entirely of performing abortions.

56. Dr. Haskell's recollection of his experiences is that he has never had a serious complication with a D&X, but he has had 2-3 serious uterine perforations with his 20 years of performing 3,000 D&E abortions past 20 weeks gestation.

57. Dr. Haskell does not have a precise moment when he intends fetal death to occur during D&E and D&X abortions.

58. Dr. Haskell did not note in patient records whether he performed a D&E or D&X abortion. He does note complications in individual patient files.

59. The data on complications that Dr. Haskell reports to the National Abortion Federation does not distinguish between D&E and D&X abortions.

60. If there has not been a complication, women who have had D&E or D&X abortions are on an equal footing with regard to their health when they leave Dr. Haskell's clinic.

61. On September 13, 1992, Dr. Haskell presented a paper entitled "Dilation and Extraction for Late Second Trimester Abortion" at a Risk Management Seminar of the National Abortion Federation. The Haskell paper is exhibit 204.

62. On April 2, 1995, James T. McMahon, M.D. (deceased), presented a paper entitled "Intact D&E, The First Decade" at a conference of the National Abortion Federation. The McMahon paper describes variations on the same procedures described in the Haskell paper, but the McMahon paper does not use the label "D&X." The McMahon paper is exhibit 18.

63. In exhibit 18, Dr. McMahon describes the intact D&E as "an aggregation of strategies and techniques designed to remove the fetus and placenta without disruption." Dr. McMahon describes three techniques, depending on whether the fetus is presenting head first or breech, or is in some transverse position. In all three situations, Dr. McMahon describes "slow and gentle" dilation before proceeding further. When the skull is down, Dr. McMahon's technique involves puncturing and aspirating the skull, administering medication to cause uterine contractions, and as the skull collapses and the uterine contractions cause it to be expelled, using routine maneuvers to remove the remainder of the fetus. If the presentation is breech, Dr. McMahon's technique involves first converting the fetus to a foot-down position, using standard maneuvers to extract the fetus intact, and when the skull becomes lodged in the cervix puncturing the base of the skull and aspirating the skull's contents in order to allow the skull to collapse and the extraction to be completed. When the fetus is in a transverse position, Dr. McMahon describes routine obstetrical maneuvers to convert the fetus either to a foot down or skull down position before proceeding. Defendant does not dispute this description of exhibit 18, but asserts that the exhibit speaks for itself.

64. The American College of Obstetricians and Gynecologists (ACOG) has issued a "Statement on Intact Dilation and Extraction." The ACOG Statement contains a four-part definition of what ACOG labels "Intact D&X:"

1. deliberate dilation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and

4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus

The ACOG Statement is dated January 12, 1997. It is exhibit 16.

65. Plaintiffs Christensen and Smith have defined a D&X as follows:

> In the intact D&E procedure (which is also known as "dilation and extraction," "D&X" or "intact D&X"), the physician dilates the cervix and then removes the fetus from the uterus through the vaginal canal intact. The physician extracts the fetal body intact, usually feet first, until the cervix is obstructed by the after coming head, which is too large to pass through the cervix. Then the physician creates a small opening at the base of the skull and evacuates the contents, allowing the calvarium to pass through the cervical opening. The intentional removal of the fetus intact is what distinguishes an intact D&E procedure from a D&E procedure.

66. When a physician employs the "D&X" (by any definition), fetal cardiac activity and other signs of fetal life may continue after the fetus has been partially extracted intact into the vagina and before the physician performs any maneuver that will cause the death of the fetus in the course of the completion of the procedure.

67. When a physician employs the "D&X" (by any definition), fetal cardiac activity and other signs of fetal life may continue after the fetus has been extracted intact up to the skull and before the skull is punctured or crushed. Under these circumstances, all fetal cardiac activity and all

other signs of life eventually cease as a result of the steps the physician takes to crush the skull or evacuate the contents of the skull.

68. A physician who performs a "D&X" abortion (by any definition) understands that the procedure will cause the death of the fetus.

69. Physicians with experience always have the option of converting an intact procedure to a dismemberment procedure.

70. D&Xs require the same amount of skill as D&Es.

71. After the first trimester, the main alternative to a D&E abortion is an induction procedure. This procedure, which involves inducing preterm labor, is usually chosen for procedures after 20 weeks gestation, or earlier if the woman's medical condition precludes a D&E (for example when the woman or the fetus is too large). It is also chosen when an intact fetus is desirable to facilitate diagnosis of an anomaly and counseling about future pregnancies, or when the woman desires to hold and grieve for the dead fetus.

72. In an induction, the physician uses laminaria to dilate the cervix and introduces medications into the patient that will both continue the dilation and induce labor. As a result of the labor, the fetus is expelled from the woman's uterus. Inductions are always performed in hospitals.

73. Sometimes, during an induction, the physician must assist in the removal of the fetus; and sometimes the physician must collapse or compress the skull or some part of the fetal abdomen to allow it to pass through the cervix. Sometimes it is necessary for the physician to dismember the fetus in order to complete its removal from the uterus.

74. During inductions, fetal demise can occur at different times and from different causes. Sometimes, the cessation of fetal cardiac activity and other signs of fetal life will not occur until after the fetus has partially emerged or been partially extracted through the cervix. Sometimes the cessation of fetal cardiac activity and other signs of fetal life will not occur until after the fetus has entirely emerged or been extracted through the cervix.

75. In every induction procedure performed on a non-viable fetus, all fetal cardiac activity and all other signs of life eventually cease.

76. A physician who performs a pre-viability induction procedure understands that fetal demise is the inevitable outcome of the steps he takes to conduct the procedure.

77. During inductions, fetal demise can occur at different times and from different causes.

78. The remaining procedures for performing an abortion are hysterotomy or hysterectomy, both of which are major surgical procedures that require hospitalization and are rarely performed because of the risks they pose.

79. For second trimester abortions, physicians in the 1970s used hysterotomy or saline amnioinfusions. In a saline amnioinfusion, the physician inserted a needle into the amniotic sac replacing some of the amniotic fluid with a saline solution.

80. The American Medical Association has stated the following concerning D&Xs:

> To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some

> physicians use . . . (D&X). . . . This procedure may minimize trauma to the woman's uterus, cervix, or other vital organs. Intact D&X may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb.
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> * * *
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> 3. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

Report of the Board of Trustees on Late-Term Pregnancy Termination Techniques, American Medical Association, May 1997, at 15 (Exhibit 17).

81. The American College of Obstetricians and Gynecologists ("ACOG"), of which plaintiffs Broekhuizen, Jacobson, Sender, Prohaska and Christensen are fellows, issued a Statement of Policy on Intact Dilatation and Extraction that provides:

> A select panel convened by ACOG could identify *no* circumstances under which this procedure [intact D & X], as defined above, would be the only option to save the life or preserve the health of the woman. An intact

> D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision.

1/12/97 ACOG Statement of Policy, Statement on Intact Dilatation and Extraction (Ex. 16).

82. Dr. Stubblefield can recall one occasion when he performed the head-first version of the D&X as he described it. In that procedure, the fetus was dead when he punctured the skull.

83. Dr. Stubblefield has never performed a D&X on any other occasion.

84. Dr. Stubblefield has never seen a D&X performed on any other occasion.

85. Dr. Stubblefield has never referred a patient to another physician to have a D&X abortion performed.

86. Dr. Stubblefield has never offered a D&X abortion to one of his patients as an option.

87. Dr. Stubblefield, the members of his faculty and the residents, under his supervision perform vacuum curettage abortions up through 12 weeks gestation and a variation of D&E using laminaria to dilate the cervix followed by forceps and vacuum evacuation up through 17 weeks. At weeks 18, 19 and 20 they perform labor induction abortions. They do not perform abortions later than 20 weeks.

88. Dr. Stubblefield is not aware of any physician performing D&X abortions prior to 20 weeks LMP.

89. Dr. Stubblefield has never performed any abortions in Wisconsin, nor had any patients from Wisconsin.

90. There are no published medically-recognized studies comparing the risks of D&E to D&X.

91. For second trimester abortions, Dr. Stubblefield considers the D&E or D&X safest.

92. Dr. Stubblefield has never discussed offering a woman a D&X.

93. Dr. Stubblefield is not aware of any consent forms that disclose the relative safety of D&E abortions as compared to D&X abortions.

94. Dr. Smith reported that "In general the D&E is considered the safest procedure, especially in comparison to induction."

95. Dr. Smith has never referred a patient less than 22 weeks pregnant to another physician to have a D&X abortion performed.

96. Dr. Jacobson has never performed a D&X abortion as defined by ACOG.

97. Although Dr. Jacobson was taught D&E, induction and suction curettage abortion methods, he was not trained in D&X.

98. Dr. Jacobson has never seen a D&X abortion performed.

99. Dr. Jacobson has never offered a woman a D&X as an option.

100. Dr. Jacobson teaches residents vacuum aspiration, medical induction methods and D&E. But there is no training in D&X.

101. Dr. Jacobson has never referred a patient to another doctor for a D&X abortion.

102. Dr. Jacobson can understand individually each term in the definition of "partial-birth abortion" in Wis. Stat. § 940.16.

103. Surgical skill is probably the largest determinant of the safety of D&E and D&X methods.

104. Plaintiff Broekhuizen has performed at least three procedures in the past few years where he intended and expected to perform procedures that fit Dr. Haskell's description of D&X and the procedures described by Dr. McMahon.

105. In one case, Dr. Broekhuizen set out to perform a D&X abortion on a pregnancy where the child was just two days short of 24 weeks gestation. Dr. Broekhuizen did the serial dilation and then the fetus was completely expelled intact.

106. Dr. Broekhuizen is not aware of any comparison between D&E and D&X abortions in the literature.

107. In a second case where Dr. Broekhuizen planned to do an intact extraction without collapsing the head. The child was about 20 weeks gestation and the mother had problems with the destruction of the fetus in the D&E and she had "an inordinate fear of labor pains," so she did not want an

induction. The serial dilation led to a spontaneous onset of labor and an intact fetus was delivered.

108. In a third case where Dr. Broekhuizen set out to perform a D&X procedure, the fetus was 28 weeks with the fetal anomaly of hydrocephalus. Its head was larger than that of a term baby. Dr. Broekhuizen performed a combination of dilation and induction, and then decompressed the head with scissors and needles and completed delivery.

109. Dr. Broekhuizen is unaware of any peer-reviewed journal articles on D&X abortions.

110. Dr. Broekhuizen views the definition of D&X in Dr. Smith's declaration as consistent with what is being described by other physicians, but would include crushing the skull with forceps as well as creating a small hole in the base of the skull and suctioning out the contents.

111. Dr. Broekhuizen usually does induction procedures after 20 weeks because he is not comfortable personally doing D&E's a lot after 20 weeks.

112. Dr. Broekhuizen does not ordinarily give a patient the option between a D&E and D&X.

113. Dr. Broekhuizen believes comparisons of the risks of D&E to D&X would be valuable information for women to have, but is unaware of any head-to-head comparison.

114. Dr. Christensen sometimes performs abortions in which he utilizes elements of the D&X technique developed by Dr. Haskell. Specifically, Dr. Christensen performs one or two procedures per year in which he pulls the fetal body out of the uterus until the fetal head lodges at the cervix, and then pierces the skull and suctions out the cranial contents to permit delivery of the fetal head.

115. Plaintiff Christensen has performed one or two procedures per year that fit the description in paragraph 36. He does not notate his medical records to indicate the precise technique he has used on a particular patient. Thus, he is unable to determine from his records on which women he performed that procedure.

116. Dr. Christensen drafted the press release he issued on May 21, 1998 (Ex. 208).

117. Dr. Christensen does not always try to remove the fetus as intact as possible.

118. Dr. Christensen does not discuss the D&E method compared to the D&X method with his patients.

119. Dr. Christensen uses the same consent form for suction curettage, D&E and D&X abortions.

120. Dr. Christensen does not have clinical statistics for complications differentiating between D&E and D&X abortions.

121. Dr. Christensen is not aware of any physician who uses consent forms that distinguish between D&E and D&X abortions.

122. As Clinical Assistant Professor at the University of Wisconsin Medical School, Dr. Christensen offers OB/GYN residents a rotation at his clinic. Dr. Christensen trains the residents in suction curettage.

123. The residents observe Dr. Christensen do D&E and D&X abortions, but they do not perform those procedures.

124. Dr. Christensen described the Journal of the American Medical Association (JAMA) as a peer-reviewed, official publication of the American Medical Association that

is "first-rate." He could not recall whether he read the August 1998 issue of JAMA concerning late second trimester abortions.

125. Dr. Christensen's rate of complications from abortions did not go up in a "statistically significant fashion" while Wis. Stat. § 940.16 was in effect.

126. Dr. Christensen does not have any specific recollection of the cases in which he used the D&X abortion method and does not keep records in a manner that would allow him to ascertain which patients they were.

127. Dr. Giles supports legal elective abortions for women. He has performed elective abortions. Between one fourth and one third of all the abortions he has performed have been elective.

128. Dr. Giles has performed abortions up to 23 weeks of gestation. He is familiar with the suction curettage, D&E, D&X and medical induction abortion methods, which are described in plaintiffs' declarations.

129. Dr. Giles is not aware of any scientific study demonstrating that the D&X procedure is safer than other procedures used for aborting the fetus at the same gestational age.

130. Dr. Giles is not aware of any medical schools teaching D&X abortions nor any medical textbooks that describe D&X abortions.

131. Dr. Giles' concerns with partial-birth abortion include pain to the child, denying the child any possibility of survival, and maternal health.

132. Only at gestational ages beyond 24 weeks, Dr. Giles has used cervical relaxants to bring the head out.

133. Dr. Giles has performed 2,000-3,000 abortions over the course of his 30 years of medical practice.

134. Dr. Giles has performed inductions, suction abortions, D&C abortions, D&E abortions, hysterectomies and hysterotomies.

135. On May 14, 1997, the AMA sent a letter to United States Senator Rick Santorum stating its support of H.R. 1122 ("The Partial Birth Abortion Act of 1997), then pending in the United States Congress. It is exhibit 201. Plaintiffs object to this exhibit on the grounds of hearsay and relevance.

136. Hearings have been held in the United States Congress on the issue of "partial birth abortion." A record of the hearings before the House of Representatives ("Partial-Birth Abortion: Hearing Before the Subcommittee on the Constitution of the Committee on the Judiciary House of Representatives," 104th Cong. 1st Sess. 31 (June 15, 1995)) is exhibit 202. A record of the hearings before the United States Senate ("Hearing Before the Committee On the Judiciary, United States Senate, on H.R. 1833, An Act To Amend Title 18 United States Code, To Ban Partial Birth Abortion." 104th Cong. 1st Sess (Nov. 17, 1995) is exhibit 203. Plaintiffs object to these exhibits on grounds of hearsay and relevance.

137. The Journal of the American Medical Association published an article entitled, "Late-Term Abortion," 280 JAMA 724 (August 26, 1998). That article is exhibit 205.

138. The Journal of the American Medical Association published an article entitled, "Rationale for Banning Abortions Late In Pregnancy," 280 JAMA 744 (August 26, 1998). That article is exhibit 206. Plaintiffs

object to this exhibit on the grounds of hearsay and relevance.

139. The Journal of the American Medical Association published an article entitled, "The Continuing Need for Late Abortions," 280 JAMA 747 (August 26, 1998). That article is exhibit 207. Plaintiffs object to this exhibit on the grounds of hearsay and relevance.

Dated: May , 1999

Respectfully submitted,

/s/

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